ENROLLMENT FORM

(Change in Family Status)

City of Richardson

Employee Name	
Social Security Number	Effective Date of Change

Reason for Change

Marriage ☐ Divorce ☐ Birth or Adoption of Child ☐ Change in spouse's employment ☐ Open Enrollment ☐

Other ☐ If other, explain: _____

Coverage Type

Self ($50 per mo) ☐ Self + 1 Dependents ($192 per mo) ☐ Self + 2 or more dependents ($237 per mo) ☐

Name of Person to be Covered	Date of Birth	Address	Gender	Relationship to Employee
			☐ F ☐ M	
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			☐ F ☐ M	
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Name of Person to be Covered	Date of Birth	Address	Gender	Relationship to Employee
			☐ F ☐ M	

OTHER COVERAGE:

☐ Spouse has other insurance coverage (this plan is secondary) ☐ Spouse has **NO** other insurance overage.

☐ Dependent(s) have other insurance coverage (this plan is secondary) ☐ Dependent(s) have **NO** other insurance overage.

If yes, type of coverage: ☐ Medical ☐ Dental ☐ Medicare A Subscriber ☐ Medicare B Subscriber

Person(s) covered: ☐ Spouse ☐ Family

LIST OTHER INSURANCE COVERAGE:

Name of Carrier: _____

Address of Carrier: _____

I authorize the City of Richardson to deduct my portion of the insurance premium from my gross pay on a before-tax basis. I understand that one-half of the monthly premium will be deducted every pay period. I understand and acknowledge that the information I have provided is true and accurate to the best of my knowledge.

_____ Employee Signature

_____ Date

GWLA/EHS
AS400 ABT
AS400 INS.
COBRA
CARDS
HIPAA